



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

DOWNTOWN PERFORMANCE MEDICAL CENTER
3033 FANNIN STREET
HOUSTON TX 77004

Respondent Name

AMERICAN ECONOMY INSURANCE CO

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-12-3460-01

MFDR Date Received

JULY 26, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "We are requesting your assistance for payment on the above services these bills has been submitted via fax to several given numbers and mailed certified..."

Amount in Dispute: \$1,411.80

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: The requestor did not respond to the request for medical fee dispute resolution.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 9, 2011 August 11, 2011 August 15, 2011 August 18, 2011 August 25, 2011	Physical Therapy Services	\$1,411.80	\$1,090.20

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers' compensation medical bills for reimbursement.
3. 28 Texas Administrative Code §102.4 sets out the rules for non-Commission communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. 28 Texas Administrative Code §134.203 sets out the fee guidelines for professional services.

7. The services in dispute were reduced/denied by the respondent with the following reason codes:

- 1 – 29 – The time limit for filing has expired.
- 2 – 18 – Duplicate claim/service
- 3 – 198 – Precertification/authorization exceeded.
- 5 – Number of Occurrences on Authorization record has been exceeded.

Issues

1. What is the timely filing deadline applicable to the medical bills for the services in dispute?
2. Is the requestor due reimbursement for the services in dispute?

Findings

1. 28 Texas Administrative Code §133.20(b) states, in pertinent part, that, except as provided in Texas Labor Code §408.0272, “a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided. In accordance with subsection (c) of the statute, the health care provider shall submit the medical bill to the correct workers' compensation insurance carrier not later than the 95th day after the date the health care provider is notified of the health care provider's erroneous submission of the medical bill. A health care provider who submits a medical bill to the correct workers' compensation insurance carrier shall include a copy of the original medical bill submitted, a copy of the explanation of benefits (EOB) if available, and sufficient documentation to support why one or more of the exceptions for untimely submission of a medical bill under §408.0272 should be applied...” Review of the documentation submitted by the requestor finds that the respondent did not uphold that denial; therefore, there is no longer an untimely filing issue and the disputed dates of service will be reviewed in accordance with Division rules and the Labor Code.
2. The requestor submitted documentation supporting that payment was received for dates of service August 1, August 2, August 4, and August 8, 2011, November 14, and November 16,. Review of the explanation of benefits received by the requestor finds that dates of service August 9, August 11, August 15, August 18, August 25, 2011 were denied by the insurance carrier using denial code “3 – Precertification/authorization exceeded” and “5 – Number of Occurrences on Authorization record has been exceeded.” The requestor submitted a copy of the preauthorization approval for physical therapy at 3 times a week for 4 weeks. Review of the documentation submitted by the requestor finds that preauthorization was not exceeded. In accordance with 28 Texas Administrative Code §134.203(B)(1) Medicare's list of therapy procedure subject to the multiple procedure payment reductions, effective January 2011, include the disputed CPT Codes 97110 and 97140. Reimbursement is recommended for the following services:

- Procedure code 97110, service date August 9, 2011, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.45 multiplied by the geographic practice cost index (GPCI) for work of 1.012 is 0.4554. The practice expense (PE) RVU of 0.41 multiplied by the PE GPCI of 0.992 is 0.40672. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.131 is 0.01131. The sum of 0.87343 is multiplied by the Division conversion factor of \$54.54 for a MAR of \$47.64. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure has the highest PE for this date. The first unit is paid at \$47.64. The PE reduced rate is \$43.20 at 3 units is \$129.60. The total is \$177.24 per date of service; therefore, total reimbursement for dates of service August 9, August 11, August 15, August 18 and August 25, 2011 is \$886.20.
- Procedure code 97140, service date August 9, 2011, represents a professional service with reimbursement determined per §134.203(c). The Medicare fee is the sum of the geographically adjusted work, practice expense and malpractice values multiplied by the conversion factor. The MAR is calculated by substituting the Division conversion factor. For this procedure, the relative value (RVU) for work of 0.43 multiplied by the geographic practice cost index (GPCI) for work of 1.012 is 0.43516. The practice expense (PE) RVU of 0.38 multiplied by the PE GPCI of 0.992 is 0.37696. The malpractice RVU of 0.01 multiplied by the malpractice GPCI of 1.131 is 0.01131. The sum of 0.82343 is multiplied by the Division conversion factor of \$54.54 for a MAR of \$44.91. Per Medicare policy, when more than one unit of designated therapy services is performed on the same day, full payment is made for the first unit of the procedure with the highest practice expense. Payment for each subsequent unit is reduced by 20% of the practice expense. This procedure does not have the highest PE for this date. The PE reduced rate is \$40.80. The total is \$40.80 per date of service; therefore, total reimbursement for dates of service August 9, August 11, August 15, August 18 and August 25, 2011 is \$204.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is \$1,090.20.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of \$1,090.20 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

_____	_____	<u>August 8, 2013</u>
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.